

HCBS Standard Operating Procedures

North Carolina supports serving individuals with disabilities in the most integrated settings possible, based on what is clinically appropriate as defined by the individual's person-centered planning process.

We believe that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards.

Through engaging beneficiary and provider stakeholders, we will create a plan that supports individuals through a person-centered process, builds upon our already existing system and supports providers to ensure compliance with rules. This webpage details North Carolina's vision of Home and Community Based Services.

The Centers for Medicare & Medicaid Services (CMS) published [a final rule for Medicaid Home and Community Based Services](#) effective March 17, 2014. The rule allows beneficiaries access to the benefits of community living and receiving services in the most integrated setting and provides alternatives to institutions. Additional information can be found at [Medicaid.gov](#).

Overall Purpose of HCBS Final Rule

To ensure that individuals receiving long-term services and supports through home and community-based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.

To enhance the quality of HCBS and provide protections to participants.

Please refer to www.ncdhhs.gov/about/departments-initiatives/home-and-community-based-services-final-rule for additional information.

Timelines

North Carolina's site validation process starts April 1, 2019 and ends March 31, 2020. Within all procedures and processes noted within this document, **ALL** sites within the transition period **MUST** be Full Integrated/Fully Compliant AND validated by March 31, 2020. All new sites outside of the transition period must be fully integrated/fully compliant PRIOR to providing services.

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Address Change

DHHS encourages the LME-MCO to ensure providers offer advanced notice to the LME-MCO of plans to move to a new location. This practice will provide the LME-MCO the opportunity to confirm/validate HCBS compliance at the new site location. All new sites must be HCBS compliant prior to providing any services at the site.

Once the LME-MCO has been notified of a provider's intent to change their physical address, the LME-MCO should request the provider to submit a new assessment for the future address.

The LME-MCO should identify the provider's current assessment and at the bottom of the self-assessment select "Not Accepted," and supply a brief description. For record purposes, this assessment will not be deleted from the system. The previous assessment's assessment number will need to be noted within the description as well as a reference point.

"This assessment is a re-submission of assessment # XXXXXXXX due to a change in address."

Since the newly submitted provider self-assessment falls outside of the transition period, the LME-MCO will need to provide specific technical assistance and deadlines to providers to reach full compliance within reasonable amount of time given the item that is not compliant.

Provider Acquisition

Provider/Agency should offer advanced notice to LME-MCO of plans to acquire an existing provider.

Once LME-MCO has been notified of a provider acquisition, the LME-MCO will request the provider to submit a new assessment for acquired site location(s). This is required due to the potential in a change in agency policy or procedures, which could have an impact on HCBS waiver services.

The LME-MCO will identify the to-be acquired provider self-assessment(s) and at the bottom of the self-assessment select “Not Accepted,” notate the previous assessment number within the comments, and supply a brief description. For records purposes this assessment will not be deleted from the system.

“This assessment is a re-submit of assessment # XXXXXXXX due to a provider acquisition.”

Since the newly submitted provider self-assessment(s) falls outside of the transition period the LME-MCO will need to ensure the site is fully compliant within **10 business days of acquisition**.

1. Review newly submitted assessment and determine if HCBS criteria has been met.
2. If assessment is considered fully integrated, no additional review is required.
3. If the assessment is considered “emerging,” the LME-MCO will need to provide technical assistance to ensure HCBS compliancy/full integration is achieved within the 10-business day timeframe.

HCBS Emergent Residential Discharge Planning

Emergent refers to a situation in which placement for a beneficiary is required within a limited timeframe.

Where emergent accommodation is utilized for a HCBS participant, the following procedures apply:

Emergent accommodation may be utilized as a temporary or permanent measure only where all alternatives have been exhausted, such as respite and family network. Emergency placement is determined by LME-MCO, not the provider.

In Network Provider: If emergent placement occurs within the authorizing LME-MCO network AND the provider site (not a part of the transition period) has not been considered HCBS compliant;

- LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days of placement.
- If HCBS compliance cannot be reached in the 5-business day period, the LME-MCO will need to decide if HCBS compliance can be made with increased technical assistance and plan of action within 30 days from placement or look for a more permanent HCBS compliant home/setting.

Out of Network Provider: If emergent placement occurs outside of the authorizing LME-MCO provider network AND the provider site has not been considered HCBS compliant;

- Provider Within Transition Period: The new LME-MCO will review the HCBS Provider Self-Assessment and remediate concerns with the current LME-MCO. If the provider self-assessment was listed on the LME-MCOs Validation Quarterly Reporting Tool, the site is considered part of the transition period. Any sites not listed would fall under new provider status. Sites in the transition period do not have to be fully compliant for emergent placement.

Out of Network Provider: If emergent placement occurs outside the authorizing LME-MCO network AND the provider has NOT completed a HCBS Provider Self-Assessment.

- Provider has 72 clock hours to complete the Provider Self-Assessment. LME-MCO will review HCBS Provider Self-Assessment and remediate to full compliance within 5 business days of completed date of newly submitted assessment.
- If HCBS compliance cannot be reached in the 5-business day period, the LME-MCO will need to decide if HCBS compliance can be made with increased technical assistance and plan of action within 30 days from placement or look for a more permanent HCBS compliant home. Sites in the transition period do not have to be fully compliant for emergent placement.

LME-MCO Site Assessment Transfer Guidelines

In the event an LME-MCO receives an assessment that belongs to another LME-MCO and they have **NOT REVIEWED** the assessment.

1. Submit a Master Index request to move assessment to responsible LME-MCO.

If an LME-MCO receives an assessment that belongs to another LME-MCO and it has been **REVIEWED** ONLY. *Reviewed means – reviewing entity staff has assigned an integration/compliance level to the responses/information noted by the provider site in the provider self-assessment.

1. Identify the responsible LME-MCO to discuss transfer and request to HCBSTransPlan@dhhs.nc.gov to forward the assessment to the correct LME-MCO
2. Both LME-MCO's will submit a Master Index with a request to reassign.

Language for Master Index request:

Requesting LME-MCO: *Assessment "X" was reviewed and determined to belong within the catchment area of "Receiving LME-MCO"*

Receiving LME-MCO: *Assessment "X" was reviewed by "Requested LME-MCO" and needs to be re-assigned to "Receiving LME-MCO"*

The process for an LME-MCO that has **REVIEWED and ACCEPTED** an assessment that belongs to another LME-MCO is as follows:

AGREEMENT

1. The LME-MCO that initially reviewed the assessment will submit a request to HCBSTransPlan@dhhs.nc.gov to forward the assessment to the correct LME-MCO.
2. If the newly reviewing LME-MCO agrees with provider responses, the process is complete and that LME-MCO will be responsible for any Plans of Action and further review.

Language for Master Index request:

Requesting LME-MCO: *Assessment "X" was reviewed and accepted. It is determined to belong within the catchment area of "Receiving LME-MCO"*

Receiving LME-MCO: *Assessment "X" was reviewed and accepted by "Requested LME-MCO" and needs to be re-assigned to "Receiving LME-MCO"*

NON-AGREEMENT

Consultation: If the newly reviewing LME-MCO is not in agreement with provider responses, they will contact the LME-MCO that completed the initial review to discuss the responses and develop plan to reach a resolution.

1. At the conclusion of the discussion the assigned LME-MCO's will only follow up specific to Plans of Actions, and no immediate action will be required unless there is still non-agreement with the findings.
2. If resolution is not possible DHHS should be notified to provide technical assistance and remediate.

HCBS Database Update: If the reviewing LME-MCO does not agree with the findings, the assigned LME-MCO will “Pending/Questions” within the provider self-assessment to address discrepancies or the assigned LME-MCO update the provider self-assessment with any remediation information to address concerns.

The need for reassignment should be noted on a Master Index submission by both LME-MCOs.

Language for Master Index request:

Requesting LME-MCO: *Assessment “X” was reviewed and accepted by “Insert LME-MCO” It is determined to belong within the catchment area of “Receiving LME-MCO”*

Receiving LME-MCO: *Assessment “X” was reviewed and accepted by “Requested LME-MCO” and needs to be re-assigned to “Receiving LME-MCO” Integration status is pending further review.*

The process, from that point, will continue as previously established.

ENDING CONTRACT WITH PROVIDER

In the event an LME-MCO would like to terminate an existing provider contract, and another LME-MCO would like to continue working or enroll the provider site with the provider site, the process is as follows:

1. Contact provider and notify intent to terminate contract and follow their contract process for provider termination.
2. Receive from the provider the LME-MCO(s) currently working with or interested in enrolling provider within their network, if applicable.
 - a. If this information is unknown to the LME-MCO, the LME-MCO would mark the assessment as “Not Accepted” and add language within the comment box as to the reason.
 - b. In the event that an LME-MCO has been made aware that a new provider or existing provider in their catchment area has an assessment in the system, this information may be requested from the HCBSTransPlan@dhhs.nc.gov email.

- c. Discussions between both LME-MCOs will need to take place and updates to the HCBS database made accordingly.

Language for Master Index request (if known):

- **Requesting LME-MCO:** Provider “X” associated with *Assessment “X” has been terminated from “Requesting LME-MCO’s” network and requesting transfer to “Receiving LME-MCO” for network enrollment and ongoing HCBS monitoring.*
- **Receiving LME-MCO:** Provider “X” associated with *Assessment “X” has been accepted for network enrollment and ongoing HCBS monitoring.*

Master Index Duplicate, Shared and Multiple Site Guidance

Service Type	Technical Assistance
Day Supports & Adult Day Health	The LME-MCO should submit a request to have duplicate Adult Day Health site removed.
Innovations & (b)(3) Supported Employment	The LME-MCO should submit a request to have duplicate (b)(3) site removed.
Innovations Residential Supports & (b)(3) DI Residential Supports	Request the LME-MCO submit request to have duplicate (b)(3) DI site removed.
Any other service bundle	<p>LME-MCO will need to review the following for accuracy:</p> <ul style="list-style-type: none"> • Did the provider select the appropriate service? Was this attributed to a drop-down error? • Is this attributed to the site being a corporate site for supported employment or are individuals working at the site? <ul style="list-style-type: none"> ○ In the event that it is a corporate site, this should be noted on the Master Index request column. • The only site that should have a corporate site representation is supported employment. All other sites should speak to where services are being provided. <ul style="list-style-type: none"> ○ Special attention should be paid towards multiple site names at the same address.
Duplicate Assessments: Due to entry errors (i.e. Drive vs. Dr. or Circle, The Home vs. Home, Martin Luther King vs. MLK, email address submitted incorrectly, etc.).	<ul style="list-style-type: none"> • LME-MCOs should review both provider self-assessments to verify the information is duplicative. If the assessments are duplicates, a Master Index request can be submitted. • LME-MCOs are able to request via Master Index an updated name and contact information for a provider. This should support with alleviating new duplicates from appearing within the system.
Shared Sites	<ul style="list-style-type: none"> • Supported employment cannot be provided out of a day support setting. Corporate site assessments can be utilized. • The catchment area LME-MCO is responsible for the validation for multiple assessments shared between 2 or more LME-MCOs. The LME-MCOs who have assessments submitted for shared sites outside of their catchment area should submit a Master Index request to delete the duplicate sites.

	<ul style="list-style-type: none"> Shared sites identified during the validation process (April 1, 2019-March 31, 2020) should follow the guidance identified for submitting Master Index requests during this period.
Provider staff change	<p>Assessment # XXXX new contact information: Email address XXXX@XXXX and contact name XXXX XXXXXXX and phone number XXX XXX-XXXX</p>

NC DHHS Home and Community Based Services (HCBS)
Heightened Scrutiny Process

The heightened scrutiny (HS) process is to be completed for all providers who have been identified as:

- in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of, or immediately adjacent to, a public institution; or
- a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

The State will not consider facilities that are in buildings that provide inpatient institutional treatment and those on the grounds of, or immediately adjacent to, a public institution for Heightened Scrutiny review.

The State will not consider farms and disability specific gated communities for Heightened Scrutiny review. If a setting is meeting one of the above criteria during the provider self-assessment process, the HS assessment will be conducted. Information gathered or identified in reviews may be submitted as evidence for the HS desk review.

1. Provider sites complete the provider self-assessment using the online tool. Whenever the provider selects ‘yes’ to any responses in **Section I: Settings That Are Not Home And Community Based, question 2**, on the provider self-assessment; the LME-MCO/DMA (CAP/DA) must initiate the HS process by requesting the Heightened Scrutiny Threshold Tool from DHHS.
2. DHHS will provide the LME-MCO/DMA (CAP/DA) with a link to the Heightened Scrutiny Threshold Tool.
3. The LME-MCO/DMA (CAP/DA) will forward the Heightened Scrutiny Threshold Tool to the provider for completion specific to the site.
4. Once the provider has completed the Heightened Scrutiny Threshold Tool, DHHS will provide the LME-MCO/DMA (CAP/DA) with the electronic link against which to review the provider’s response.
5. LME-MCO/DMA (CAP/DA) will notify DHHS if the site meets one of the above three criteria for heightened scrutiny.
6. DHHS will conduct a desk and onsite review of sites, as appropriate, that fall within the heightened scrutiny category.

- a. The LME-MCO/DMA (CAP/DA) will gather required documents from the provider site on behalf of DHHS in preparation for the desk review DHHS will conduct prior to making its site visit, if determined necessary.
- b. Upon notification of the heightened scrutiny site, all required documents should be submitted to the HCBSTransPlan@dhhs.nc.gov by the LME-MCO/DMA via secure message within 7 business days.
- c. DHHS will conduct desk reviews within 14 calendar days of receipt of documents. If additional information is required for review of documents, DHHS will reach out to the LME-MCO/DMA and will have an additional 14 calendar days to review all documents submitted.
 - i. If an onsite visit is required, DHHS will schedule it within 10 business days of the completed desk review and it will be conducted within 60 calendar days.
 - ii. If it is determined an onsite visit will not be conducted, DHHS will issue a letter to the LME-MCO/DMA and the provider explaining why. The reasons may include the following:
 - 1. Based on the desk review, DHHS determined the site will not be able to overcome its institutional presumption, even with remediation. *The process will move to step 8. *
 - 2. Based on the desk review, documentation does not support the institutional presumption. Therefore, the initial self-assessment review process will move forward.
 - 3. The provider has removed the site from the review process, and declined to continue providing HCBS waiver services.
- d. DHHS will conduct onsite reviews of the setting(s) accompanied by LME-MCO/DMA (CAP/DA) staff.
- e. A HS Committee will review results from the desk and onsite reviews after one or both have been completed. The committee will include DHHS and LME-MCO/DMA (CAP/DA) representation, the review will be completed

within 30 calendar days after receiving the desk review and the onsite review, if an onsite is completed.

2. Based upon the desk and onsite reviews, DHHS will make an initial determination if the site can overcome the institutional presumption or cannot overcome the institutional presumption.
 - a. If DHHS determines the site *may* be able to overcome the institutional presumption, the site will undergo CMS's heightened scrutiny process. To initiate that process, DHHS:
 - i. Will notify LME-MCO, Local Lead Agency (LLA), provider, individuals, and families of status and next steps.
 - ii. May ask for additional plan of action steps and timelines that assist the site with becoming fully compliant with the rule. Any additional action steps and timelines requested must be submitted within 14 calendar days.
 - iii. Will compile the evidence for the setting using the information/documentation gathered prior to the site review.
 - iv. Will post evidence reviewed and received during the HS desk and onsite review to the DHHS HCBS website. HIPAA protected information will not be posted.
 - v. Will notify public of HS public comment period for each site undergoing this process – Public notice will be posted on the state's HCBS website (<https://www2.ncdhhs.gov/hcbs/index.html>), posted in local newspaper, and disseminated to the LME-MCO, LLA, and HCBS stakeholder groups.
 - vi. Will submit request to CMS for HS review including the site's evidence and public feedback. CMS will make the final determination of the site's HCBS site status.
 - b. If DHHS determines the site cannot overcome the institutional presumption, DHHS will:
 - i. Notify the LME-MCO, Local Lead Agency, and DMA (CAP/DA) of next steps via written notification.

- ii. Work with individuals, provider and LME-MCO/LLA/DMA to create transition plans for individuals.
- iii. Participate in quarterly transition meetings/calls hosted by the LME-MCO and LLA (as applicable) until all individuals are transitioned/relocated. Transition meetings/calls will occur more frequently if needed.
- iv. The provider is required to submit a quarterly report to the LME-MCO/DMA (CAP/DA) to include the following information:
 - Member Name
 - Member and LRP Notification Date
 - Transition Planning Activities
 - Providers Toured
 - Providers Yet to be Toured
 - Tentative Transition Date
 - Tentative Transition Plan
 - Official Transition Date (once Transition has taken place)
- ii. Quarterly reports are to be submitted within the first month of each quarter. The LME-MCO(s) will review the report, follow up accordingly and submit the report along with any additional feedback to the HCBSTransPlan@dhhs.nc.gov email.
- v. Complete all transitions by March 19, 2019.

New Business HCBS Heightened Scrutiny Sites

A setting presumed to have the qualities of an institution cannot be determined to be compliant with the home and community-based setting regulatory requirements until it is operational and occupied by beneficiaries receiving services there. To comply with the HCBS settings regulations, requirements beyond the physical structure of the setting itself must be met. These requirements ensure that the individuals residing or receiving services in the setting experience the setting in a manner that promotes independence and community integration.

For the Heightened Scrutiny process, a new site could mean, a facility that is under new construction, a new site not open and wants to begin using Medicaid HCBS waiver services for its individuals after March 17, 2014 or an existing site that is operational but now wants to utilize Medicaid HCBS waiver services.

As indicated in the HCBS final regulations, any setting in which services were not being provided under an approved state plan, waiver or demonstration as of March 17, 2014, must follow the regulations for HCBS settings.

New Construction

It was CMS' expectation that after the publication of the final regulation, stakeholders would not invest in the construction of settings that are presumed to have institutional qualities, but would instead create options that promote full community integration, per the regulatory requirements for the 1915(c) waiver program, the 1915(i) HCBS state plan option, and the 1915(k) Community First Choice state plan option, found in 42 CFR 441.301(c)(4)(i), 441.710(a)(1)(i), and 441.530(a)(1)(ii), respectively. CMS strongly encourages states to limit the growth of these settings.

DHHS recommends providers consult with the Department prior to breaking ground with the intent to provide HCBS waiver services if the following may apply:

- in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of, or immediately adjacent to, a public institution;
- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;
- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community.

DHHS cannot guarantee CMS approval as an HCBS waiver provider. The Department will review and address these situations individually.

Non-Operational Site

DHHS recommends providers consult with the Department prior to opening a provider site with the intent to provide HCBS waiver services if the following may apply:

- in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of, or immediately adjacent to, a public institution;
- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;
- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community. HS cannot be assessed on a site that is not operational.

DHHS cannot guarantee CMS approval as an HCBS waiver provider. The Department will address these situations individually.

Operational Non-Waiver Sites

Service provider sites that provide non-waiver services and wish to become a HCBS waiver provider site may be assessed for HS. Sites that meet the characteristics listed in **Section I: Settings That Are Not Home And Community Based, question 2**, on the provider self-assessment or is;

- A farmstead or disability-specific farm community where individuals have limited access to the broader community outside the farm;

- A gated/secured community for only people with disabilities and the staff working with them, where the majority of their residential, day supports and other services are provided within the perimeters of that community and regular access to the broader community is limited; and
- Other settings where individuals receiving services have limited interaction with the broader community.

A desk and/or onsite review may be conducted following the process outlined above. Onsite reviews and interviews will be gathered to monitor how the individuals currently served engage in the community.

Glossary

Duplicate Provider Self-Assessment	As assessment containing the same site information (i.e. name, site name, location, service type, etc.) within the HCBS Database.
Insufficient Status	Non-compliant with HCBS: At least some elements conflict with the requirements of the rule.
Emerging Status	Partially Compliant HCBS: Some elements may support the requirements of HCBS rule, but not all elements are present.
Full Integration Status	All elements support the requirements of the HCBS rule.
Fully Compliant Status	Compliant with HCBS: All elements support the requirements of the HCBS rule.
HCBS-Home and Community Based Services	The Home and Community Based Services (HCBS) final rule directed the Department of Health and Human Services (DHHS) to ensure individuals receiving services through its 1915(c) waivers have full access to the benefit of community living and the opportunity to receive services in the most integrated setting possible.
Heightened Scrutiny	<p>CMS has provided guidance that settings that meet the criteria below must go through the heightened scrutiny (HS) process to ensure the setting can overcome the presumption of having "qualities" of an institution:</p> <ul style="list-style-type: none"> • In a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; • located in the building on the grounds of, or immediately adjacent to, a public institution; or • a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.
Provider Self-Assessment	Initial tool used to make the determination if sites meet compliance with HCBS final rule.

Additional Resources

- NC DHHS Home and Community Based Settings (HCBS) Self-Assessment Companion Document:
<https://files.nc.gov/ncdhhs/documents/files/hcbs/Companion-Guide-Assessment.pdf>